FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031971

Facility Name: GREENWOOD CARE LTD.

Address: 1406 N. CHICAGO AVE. (Number) EVANSTON (City) 60201 (Zip Code)

County: COOK

Telephone Number: (847) 328-7508 **Fax #** (847) 869-4878

IDPA ID Number: 363487508001

Date of Initial License for Current Owners: 01/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) CARY C. BUXBAUM, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	145	Intermediate (ICF)	145	52,925	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	48,666	485		49,151	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	48,666	485		49,151	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.87%

D. How many bed-hold days during this year were paid by Public Aid?
2196 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	138,202	17,303	24,396	179,901		179,901	(14,708)	165,193			1
2	Food Purchase		174,764		174,764	(13,925)	160,839	(17)	160,822			2
3	Housekeeping	123,550	20,061		143,611		143,611	493	144,104			3
4	Laundry		11,097	14,455	25,552		25,552		25,552			4
5	Heat and Other Utilities			105,878	105,878		105,878	1,584	107,462			5
6	Maintenance	36,770		114,158	150,928		150,928	(30,063)	120,865			6
7	Other (specify):*							4,656	4,656			7
8	**TOTAL General Services**	298,522	223,225	258,887	780,634	(13,925)	766,709	(38,055)	728,654			8
	B. Health Care and Programs											
9	Medical Director			1,800	1,800		1,800		1,800			9
10	Nursing and Medical Records	722,389	17,237	64,909	804,535		804,535	(14,085)	790,450			10
10a	Therapy	53,800	2,640	15,851	72,291		72,291	(3,801)	68,490			10a
11	Activities	144,592	13,125	1,050	158,767		158,767		158,767			11
12	Social Services	186,367			186,367		186,367		186,367			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							4,497	4,497			15
16	**TOTAL Health Care and Programs**	1,107,148	33,002	83,610	1,223,760		1,223,760	(13,389)	1,210,371			16
	C. General Administration											
17	Administrative	72,664		378,051	450,715		450,715	(304,530)	146,185			17
18	Directors Fees											18
19	Professional Services			121,617	121,617	(2,500)	119,117	(64,828)	54,289			19
20	Dues, Fees, Subscriptions & Promotions			26,692	26,692		26,692	(5,452)	21,240			20
21	Clerical & General Office Expenses	111,150	17,793	41,915	170,858		170,858	27,487	198,345			21
22	Employee Benefits & Payroll Taxes			254,932	254,932	13,925	268,857	(4,956)	263,901			22
23	Inservice Training & Education											23
24	Travel and Seminar			950	950		950	295	1,245			24
25	Other Admin. Staff Transportation			262	262		262	2,795	3,057			25
26	Insurance-Prop.Liab.Malpractice			45,528	45,528		45,528	932	46,460			26
27	Other (specify):*							22,320	22,320			27
28	**TOTAL General Administration**	183,814	17,793	869,947	1,071,554	11,425	1,082,979	(325,937)	757,042			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,589,484	274,020	1,212,444	3,075,948	(2,500)	3,073,448	(377,381)	2,696,067			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GREENWOOD CARE LTD. #0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			82,967	82,967		82,967	55,371	138,338			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			672	672		672	356,122	356,794			32
33	Real Estate Taxes			131,213	131,213	2,500	133,713	3,358	137,071			33
34	Rent-Facility & Grounds			476,280	476,280		476,280	(476,280)				34
35	Rent-Equipment & Vehicles			11,741	11,741		11,741	6,560	18,301			35
36	Other (specify):*							8,459	8,459			36
37	**TOTAL Ownership**			702,873	702,873	2,500	705,373	(46,410)	658,963			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,387	79,387		79,387		79,387			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			79,387	79,387		79,387		79,387			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,589,484	274,020	1,994,704	3,858,208		3,858,208	(423,791)	3,434,417			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(25,124)	30		9
10	Interest and Other Investment Income	(4,034)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(17)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(340)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,936)	21		24
25	Fund Raising, Advertising and Promotional	(2,467)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(9,441)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(32,440)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (78,799)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(344,992)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (344,992)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (423,791)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GREENWOOD CARE LTD.

ID# 0031971

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	IL COUNCIL (COPE)	$ (2,875)	20	1
2	NON-ALLOWABLE EMPLOYEE BENEFITS	(4,956)	22	2
3	OFFICE EXP - BUILDING	(23)	21	3
4	CAPITALIZED R&M	(16,270)	6	4
5	PRIOR PERIOD MGT FEES	(1,588)	17	5
6	NON-ALLOWABLE LEGAL FEES	(6,728)	19	6
7				7
8				8
9				9
10				10
11				11
12				12
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91				91

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary					(14,708)							(14,708)	1
2	Food Purchase	(17)											(17)	2
3	Housekeeping			493									493	3
4	Laundry													4
5	Heat and Other Utilities			594	990								1,584	5
6	Maintenance	(16,270)		441	(8,198)	(6,036)							(30,063)	6
7	Other (specify):*				537	4,119							4,656	7
8	**TOTAL General Services**	(16,287)		1,528	(6,671)	(16,625)							(38,055)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records				(14,085)								(14,085)	10
10a	Therapy					(3,801)							(3,801)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				2,725	1,772							4,497	15
16	**TOTAL Health Care and Programs**				(11,360)	(2,029)							(13,389)	16
	C. General Administration													
17	Administrative	(1,588)		11,357	(44,828)	(260,252)		(9,219)					(304,530)	17
18	Directors Fees													18
19	Professional Services	(6,728)		(61,810)	(6,446)	10,086		70					(64,828)	19
20	Fees, Subscriptions & Promotions	(5,682)		58	129			43					(5,452)	20
21	Clerical & General Office Expenses	(14,400)	23	36,025	5,774			65					27,487	21
22	Employee Benefits & Payroll Taxes	(4,956)											(4,956)	22
23	Inservice Training & Education													23
24	Travel and Seminar			83	212								295	24
25	Other Admin. Staff Transportation			466	2,329								2,795	25
26	Insurance-Prop.Liab.Malpractice			307	493			132					932	26
27	Other (specify):*			6,573	6,372	8,998		377					22,320	27
28	**TOTAL General Administration**	(33,354)	23	(6,941)	(35,965)	(241,168)		(8,532)					(325,937)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(49,641)	23	(5,413)	(53,996)	(259,822)		(8,532)					(377,381)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(25,124)	75,775	1,826	2,894								55,371	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(4,034)	356,650	810	2,696								356,122	32
33	Real Estate Taxes			1,111	2,247								3,358	33
34	Rent-Facility & Grounds		(476,280)										(476,280)	34
35	Rent-Equipment & Vehicles			1,890	3,615			1,055					6,560	35
36	Other (specify):*		8,459										8,459	36
37	TOTAL Ownership	(29,158)	(35,396)	5,637	11,452			1,055					(46,410)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(78,799)	(35,373)	224	(42,544)	(259,822)		(7,477)					(423,791)	45

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		
				GREENWOOD		
				CARE LLC	EVANSTON	BUILDING CO.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 476,280	GREENWOOD CARE LLC		$	$ (476,280)	1
2	V	32	INTEREST INCOME	151	GREENWOOD CARE LLC			(151)	2
3	V	32	INTEREST EXPENSE		GREENWOOD CARE LLC		356,801	356,801	3
4	V	30	DEPRECIATION		GREENWOOD CARE LLC		75,775	75,775	4
5	V	36	AMORTIZATION		GREENWOOD CARE LLC		8,459	8,459	5
6	V	21	OFFICE EXPENSE		GREENWOOD CARE LLC		23	23	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 476,431			$ 441,058	$ * (35,373)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	PREFERRED BOOKKEEPING	100.00%	$ 493	$ 493	15
16	V	5	UTILITIES		PREFERRED BOOKKEEPING	100.00%	594	594	16
17	V	6	REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	441	441	17
18	V	17	ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	11,357	11,357	18
19	V	19	PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	1,290	1,290	19
20	V	20	DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	58	58	20
21	V	21	CLERICAL		PREFERRED BOOKKEEPING	100.00%	36,025	36,025	21
22	V	24	SEMINARS		PREFERRED BOOKKEEPING	100.00%	83	83	22
23	V	25	ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	466	466	23
24	V	26	INSURANCE		PREFERRED BOOKKEEPING	100.00%	307	307	24
25	V	27	EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	6,573	6,573	25
26	V	30	DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	1,826	1,826	26
27	V	32	INTEREST		PREFERRED BOOKKEEPING	100.00%	810	810	27
28	V	33	REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	1,111	1,111	28
29	V	35	EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	1,890	1,890	29
30	V								30
31	V								31
32	V	19	ACCOUNT./BOOKKEEPING	63,100	PREFERRED BOOKKEEPING	100.00%		(63,100)	32
33	V	19	COMPUTER	3,480	PREFERRED BOOKKEEPING	100.00%	3,480		33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 66,580			$ 66,804	$ * 224	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	S.I.R. MANAGEMENT, INC.	100.00%	$ 990	$ 990	15
16	V	6	REPAIRS AND MAINT.	13,056	S.I.R. MANAGEMENT, INC.	100.00%	4,858	(8,198)	16
17	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	537	537	17
18	V	10	NURSING	28,716	S.I.R. MANAGEMENT, INC.	100.00%	14,631	(14,085)	18
19	V	15	EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	2,725	2,725	19
20	V	17	ADMINISTRATIVE	50,868	S.I.R. MANAGEMENT, INC.	100.00%	6,040	(44,828)	20
21	V	19	PROFESSIONAL FEES	11,748	S.I.R. MANAGEMENT, INC.	100.00%	5,302	(6,446)	21
22	V	20	FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	129	129	22
23	V	21	CLERICAL & GENERAL	14,796	S.I.R. MANAGEMENT, INC.	100.00%	20,570	5,774	23
24	V	24	EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	212	212	24
25	V	25	OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	2,329	2,329	25
26	V	26	INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	493	493	26
27	V	27	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,372	6,372	27
28	V	30	DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	2,894	2,894	28
29	V	32	INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	2,696	2,696	29
30	V	33	REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	2,247	2,247	30
31	V	35	EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	3,615	3,615	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 119,184			$ 76,640	$ * (42,544)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$ 14,796	S.I.R. MANAGEMENT, INC.	100.00%	$ 4,277	$ (10,519)	15
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	805	805	16
17	V	17	ADMIN./LEGAL SALARIES	309,870	S.I.R. MANAGEMENT, INC.	100.00%	49,618	(260,252)	17
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	10,086	10,086	18
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	8,998	8,998	19
20	V								20
21	V								21
22	V	10A	SPECIAL REHAB	12,876	S.I.R. MANAGEMENT, INC.	100.00%	9,075	(3,801)	22
23	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	1,772	1,772	23
24	V								24
25	V								25
26	V	6	REPAIRS AND MAINT.	17,604	S.I.R. MANAGEMENT, INC.	100.00%	11,568	(6,036)	26
27	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,258	2,258	27
28	V								28
29	V								29
30	V	1	DIETICIAN SALARIES	9,600	S.I.R. MANAGEMENT, INC.	100.00%	5,411	(4,189)	30
31	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	1,056	1,056	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 364,746			$ 104,924	$ * (259,822)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 74,146	$ 74,146	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INS.	74,146	CCS EMPLOYEE BENEFIT GROUP	100.00%		(74,146)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,146			$ 74,146	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	ECM OWNERS COUNCIL	100.00%	$ 70	$ 70	15
16	V	20	DUES, FEES & SUBSCRIPTIONS		ECM OWNERS COUNCIL	100.00%	43	43	16
17	V	21	CLERICAL		ECM OWNERS COUNCIL	100.00%	65	65	17
18	V	26	INSURANCE		ECM OWNERS COUNCIL	100.00%	132	132	18
19	V	35	VEHICLE RENTAL		ECM OWNERS COUNCIL	100.00%	1,055	1,055	19
20	V	17	MANAGEMENT FEES	15,600	ECM OWNERS COUNCIL	100.00%		(15,600)	20
21	V	17	ADMIN. SAL. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	6,381	6,381	21
22	V	27	EMP. BEN. - M. GIANNINI		ECM OWNERS COUNCIL	100.00%	377	377	22
23	V	17	ADMIN. SALARY		ECM OWNERS COUNCIL	100.00%			23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,600			$ 8,123	$ * (7,477)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	ERIC ROTHNER	OWNER	Administrative	51.72%	SEE ATTACHED	.49	0.68%	Alloc SIR	$ 1,202	17-7	1
2	BRYAN BARRISH	OWNER	Administrative	31.03%	SEE ATTACHED	3.12	6.93%	Alloc SIR	13,035	17-7	2
3	MIKE GIANNINI	OWNER	Administrative	3.45%	SEE ATTACHED	3.12	6.93%	Alloc SIR/OC	13,124	17-7	3
4	LOUISE BERGTHOLD	OWNER	Administrative	3.45%	SEE ATTACHED	4.30	7.82%	Alloc SIR	14,408	17-7	4
5	TOM WINTER	OWNER	Administrative	1.73%	SEE ATTACHED	4.38	7.30%	Alloc Pref.BK	11,357	17-7	5
6	ARTURO ROMINIQUIT	RELATIVE	Courier	0	SEE ATTACHED	2.92	7.30%	Alloc Pref.BK	1,654	21-7	6
7	NENITA GUZMAN	RELATIVE	Dietary	0	SEE ATTACHED	3.90	7.80%	Alloc SIR	4,277	01-7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 59,057		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREFERRED BOOKEEPING SERVICES
Street Address: 4100 WEST PRATT AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 674-5200
Fax Number: (847) 674-5267

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	863,792	11	$ 6,745	$	63,100	$ 493	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	863,792	11	8,137		63,100	594	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	863,792	11	6,035		63,100	441	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	863,792	11	155,464	155,464	63,100	11,357	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	863,792	11	17,663		63,100	1,290	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	863,792	11	788		63,100	58	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	863,792	11	493,157	432,172	63,100	36,025	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	863,792	11	1,135		63,100	83	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	863,792	11	6,379		63,100	466	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	863,792	11	4,205		63,100	307	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	863,792	11	89,973		63,100	6,573	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	863,792	11	24,993		63,100	1,826	12
13	32	INTEREST	BOOK./ACCNT.INCOME	863,792	11	11,085		63,100	810	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	863,792	11	15,206		63,100	1,111	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	863,792	11	25,868		63,100	1,890	15
16										16
17										17
18										18
19	19	COMPUTER	DIRECT ALLOCATION						3,480	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 866,833	$ 587,636		$ 66,804	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	629,428	10	$ 12,680	$	49,151	$ 990	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	629,428	10	62,210	44,382	49,151	4,858	2
3	7	EMP. BEN.-GEN. SERV.	PATIENT DAYS	629,428	10	6,878		49,151	537	3
4	10	NURSING	PATIENT DAYS	629,428	10	187,368	187,368	49,151	14,631	4
5	15	EMP. BEN.-H.C.	PATIENT DAYS	629,428	10	34,893		49,151	2,725	5
6	17	ADMINISTRATIVE	PATIENT DAYS	629,428	10	77,349	77,349	49,151	6,040	6
7	19	PROFESSIONAL FEES	PATIENT DAYS	629,428	10	67,899		49,151	5,302	7
8	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	629,428	10	1,658		49,151	129	8
9	21	CLERICAL & GENERAL	PATIENT DAYS	629,428	10	263,413	213,455	49,151	20,570	9
10	24	EDUCATION & SEMINAR	PATIENT DAYS	629,428	10	2,720		49,151	212	10
11	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	629,428	10	29,820		49,151	2,329	11
12	26	INSURANCE	PATIENT DAYS	629,428	10	6,309		49,151	493	12
13	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	629,428	10	81,605		49,151	6,372	13
14	30	DEPRECIATION	PATIENT DAYS	629,428	10	37,059		49,151	2,894	14
15	32	INTEREST	PATIENT DAYS	629,428	10	34,524		49,151	2,696	15
16	33	REAL ESTATE TAXES	PATIENT DAYS	629,428	10	28,776		49,151	2,247	16
17	35	EQUIPMENT RENTAL	PATIENT DAYS	629,428	10	46,289		49,151	3,615	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 981,450	$ 522,555		$ 76,640	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: S.I.R. MANAGEMENT, INC.
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	629,428	10	$ 54,767	$ 54,767	49,151	$ 4,277	1
2	7	EMP. BEN.-DIETARY	PATIENT DAYS	629,428	10	10,305		49,151	805	2
3	17	ADMIN./LEGAL SALARIES	PATIENT DAYS	629,428	10	635,411	635,411	49,151	49,618	3
4	19	FINANCIAL CONSULTANT	PATIENT DAYS	629,428	10	129,159		49,151	10,086	4
5	27	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	629,428	10	$ 115,229	$	49,151	$ 8,998	5
6										6
7										7
8	10A	SPECIAL REHAB	SPECIAL REHAB INC.	82,944	4	58,457	58,457	12,876	9,075	8
9	15	EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	82,944	4	$ 11,413	$	12,876	$ 1,772	9
10										10
11										11
12	6	REPAIRS AND MAINT.	MAINTENANCE INC.	221,184	10	145,348	145,348	17,604	11,568	12
13	7	EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	221,184	10	$ 28,377	$	17,604	$ 2,258	13
14										14
15										15
16	1	DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	70,679	70,679	9,600	5,411	16
17	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	13,799		9,600	1,056	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,272,944	$ 964,662		$ 104,924	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 4101 W. MAIN ST.
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 74,146	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 74,146	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ECM OWNERS COUNCIL
Street Address: 6840 N. LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60646
Phone Number: (847) 676-2026
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	ECMOC MGMNT FEE INC.	96,000	9	$ 430	$	15,600	$ 70	1
2	20	DUES, FEES & SUBSCRIPTION	ECMOC MGMNT FEE INC.	96,000	9	264		15,600	43	2
3	21	CLERICAL	ECMOC MGMNT FEE INC.	96,000	9	400		15,600	65	3
4	26	INSURANCE	ECMOC MGMNT FEE INC.	96,000	9	813		15,600	132	4
5	35	VEHICLE RENTAL	ECMOC MGMNT FEE INC.	96,000	9	6,493		15,600	1,055	5
6	17	MANAGEMENT FEES	ECMOC MGMNT FEE INC.	96,000	9			15,600		6
7	17	ADMIN. SAL. - M. GIANNINI	ADMIN. HOURS	39	9	79,839	79,839	3	6,381	7
8	27	EMP. BEN. - M. GIANNINI	ADMIN. HOURS	39	9	4,713		3	377	8
9	17	ADMIN. SALARY	DIRECT ALLOCATION		6	(539)				9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 92,413	$ 79,839		$ 8,123	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	NOMURA	X		MORTGAGE	$35,561	03/01/95	$	$ 4,015,695		8.69%	$ 356,801	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HORTON INSURACE		X	INSURANCE FINANCING							672	6
7	SIR MANAGEMENT		X	WORKING CAPITAL				185,000				7
8												8
9	TOTAL Facility Related				$35,561		$	$ 4,200,695			$ 357,473	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(679)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (679)	14
15	TOTALS (line 9+line14)						$	$ 4,200,695			$ 356,794	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC SIR MANAGEMENT	X					$	$			$ 2,696	1
2	ALLOC PREF. BOOK	X									810	2
3	INTEREST INCOME-BLDG	X									(151)	3
4	INTEREST INCOME										(4,034)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (679)	21

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 132,300	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 133,071	2
3. Under or (over) accrual (line 2 minus line 1).		$ 771	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 133,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 2,500	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 137,071	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	119,541	8
	1997	121,501	9
	1998	124,628	10
	1999	127,335	11
	2000	129,713	12

2001 ACCRUAL = 2000 RE TAX 129713 * 1.03 = 133800

R/E TAXES GREENWOOD CARE=$129,713 ALLOC PREF. BOOKKEEPING =$1,111 ALLOC SIR MGT.=$2,247

TOTAL=$133,071

APPRAISAL FEE OF $2500 FOR 2001 TAXES PAID IN 2002

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GREENWOOD CARE LTD. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031971

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-18-324-019-0000	LTC PROPERTY	$ 129,713.00	$ 129,713.00
2.	SEE ATTACHED	SEE ATTACHED	$ 64,023.09	$ 2,388.98
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 193,736.09	$ 132,101.98

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,467 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 7

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility - Greenwood Care LLC		1987	$ 152,555	1
2					2
3	TOTALS			$ 152,555	3

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145			1990	$ 1,845,500	$ 75,775	35	$ 52,729	$ (23,046)	$ 817,837	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1984	2,672		20	76	76	1,191	9
10	Various			1987	24,869		20	723	723	11,338	10
11	Various			1988	27,733		20	1,146	1,146	10,853	11
12	Various			1989	21,624		20	1,016	(1,016)	10,153	12
13	Various			1990	27,300		20	1,365	1,365	17,017	13
14	Various			1991	9,846		20	491	491	5,922	14
15	Various			1992	25,025		20	1,244	1,244	12,547	15
16	Various			1993	63,911		20	3,195	3,195	27,964	16
17	Various			1994	20,319		20	1,017	1,017	7,508	17
18	Various			1995	73,839		20	3,693	3,693	24,340	18
19	Various			1996	109,220		20	5,461	5,461	30,316	19
20	Various			1997	73,171		20	3,658	3,658	16,485	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		62,327	2,312		2,449	137	16,139	68
69	Financial Statement Depreciation			82,967			(82,967)		69
70	TOTAL (lines 4 thru 69)		$ 2,387,356	$ 161,054		$ 78,263	$ (84,823)	$ 1,009,610	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,387,356	$ 161,054		$ 78,263	$ (82,791)	$ 1,009,610	1
2	SEWER WORK	1998	4,800		20	240	240	880	2
3	ROOFING	1998	12,000		20	600	600	2,150	3
4	ROOM DIVIDERS	1998	4,488		20	224	224	784	4
5	FIRE SYSTEM	1998	7,000		20	350	350	1,196	5
6	ROOFING	1998	15,300		20	765	765	2,614	6
7	MAGNETIC DOOR HOLDER	1998	1,523		20	76	76	279	7
8	RADIATOR COVERS	1998	2,290		20	115	115	450	8
9	ROOF DRAIN	1998	3,000		20	150	150	500	9
10	WINDOWS	1998	2,970		20	149	149	497	10
11	TILE,CONCRETE	1998	2,600		20	130	130	423	11
12	CONCRETE FLOOR	1998	2,400		20	120	120	380	12
13	FIRE DAMPERS	1999	27,200		20	1,360	1,360	3,513	13
14	ELEVATOR WORK	1999	3,215		20	161	161	443	14
15	BOILER	1999	18,800		20	940	940	2,115	15
16	S.I.R. ALLOCATION	1999	8,112		20	406	406	914	16
17	CALL SYSTEM	1999	2,294		20	115	115	259	17
18	PAINTING	1999	28,077		20	1,404	1,404	2,925	18
19	FLOORING	1999	1,537		20	77	77	218	19
20	ELEVATOR REPAIR	1999	1,000		20	50	50	129	20
21	CONDENSATE PUMP	1999	1,410		20	71	71	148	21
22	ASBESTOS ABATEMENT	1999	2,940		20	147	147	306	22
23	PAINTING	1999	34,697		20	1,735	1,735	3,615	23
24	PAINTING	1999	45,426		20	2,271	2,271	4,542	24
25	CUBICLE CURTAINS	1999	11,333		20	567	567	1,134	25
26	FLOORING	1999	6,258		20	313	313	626	26
27	FLOORING	2000	30,830		20	1,542	1,542	3,084	27
28	FLOORING	2000	7,498		20	375	375	750	28
29	FLOORING	2000	13,842		20	692	692	1,326	29
30	.FLOORING - WALLBASE	2000	3,637		20	182	182	334	30
31	PAINTING	2000	5,667		20	283	283	566	31
32	PAINTING	2000	5,831		20	292	292	584	32
33	TILE WORK	2000	49,747		20	2,487	2,487	3,938	33
34	TOTAL (lines 1 thru 33)		$ 2,755,078	$ 161,054		$ 96,652	$ (64,402)	$ 1,051,232	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,755,078	$ 161,054		$ 96,652	$ (64,402)	$ 1,051,232	1
2	WINDOW TREATMENT	2000	4,893		20	245	245	408	2
3	PEDESTRIAN DOOR	2000	2,988		20	149	149	174	3
4	BOILER WORK	2000	1,240		20	62	62	119	4
5	BOILER WORK	2000	1,600		20	80	80	147	5
6	TILE WORK	2000	3,700		20	185	185	231	6
7	WINDOW TREATMENTS	2000	1,274		20	64	64	80	7
8	BATHROOM WORK	2000	1,442		20	72	72	90	8
9	TILE WORK	2000	659		20	33	33	66	9
10	WINDOWS	2000	4,192		20	210	210	280	10
11	FLOORING	2000	5,016		20	251	251	481	11
12	ROOM DIVIDERS	2000	21,761		20	1,088	1,088	1,723	12
13	PHONE LINES	2000	1,128		20	56	56	112	13
14	TILE	2000	569		20	28	28	49	14
15	PLUMBING	2000	1,285		20	64	64	118	15
16	RADIATOR COVERS	2000	540		20	27	27	49	16
17	FRAMES / ROOM SIGNS	2000	1,313		20	66	66	115	17
18	CORIAN TOP	2000	1,224		20	61	61	112	18
19	WALK IN FREEZER	2001	23,597		20	688	688	688	19
20	DOOR SYSTEM	2001	3,255		20	54	54	54	20
21	SEWER WORK	2001	2,409		20	40	40	40	21
22	NEW WINDOWS	2001	4,384		20	37	37	37	22
23	FLOOR TILE - ELEVATOR	2001	706		20	35	35	35	23
24	WINDOW TREATMENTS	2001	956		20	36	36	36	24
25	REPLACMENT WINDOWS	2001	4,384		20	37	37	37	25
26	HVAC	2001	1,261		20	63	63	63	26
27	HVAC	2001	1,004		20	46	46	46	27
28	HVAC	2001	1,003		20	8	8	8	28
29	DOOR RESTRICTORS-ELEV	2001	3,490		20	58	58	58	29
30	MINI BLINDS	2001	463		20	6	6	6	30
31	CURTAINS	2001	69		20	1	1	1	31
32	TILE	2001	119		20	1	1	1	32
33	TILE	2001	238		20	2	2	2	33
34	TOTAL (lines 1 thru 33)		$ 2,857,240	$ 161,054		$ 100,505	$ (60,549)	$ 1,056,698	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 2,857,240	$ 161,054		$ 100,505	$ (60,549)	$ 1,056,698	1
2	COVE BASE	2001	186		20	2	2	2	2
3	MINI BLINDS	2001	280		20	2	2	2	3
4	MINI BLINDS	2001	310		20	3	3	3	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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20									20
21									21
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,858,016	$ 161,054		$ 100,512	$ (60,542)	$ 1,056,705	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Alloc SIR			1993	$ 10,315	$ 328	35	$ 295	$ (33)	$ 2,505	4
5	Alloc SIR			1993	20,866	662	35	596	(66)	5,067	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED FROM S.I.R. MANAGEMENT			1993	8,962	249	20	452	203	3,984	9
10	ALLOCATED FROM S.I.R. MANAGEMENT			1994	28		20	3	3	21	10
11	ALLOCATED FROM S.I.R. MANAGEMENT			1995	205		20	10	10	66	11
12	ALLOCATED FROM S.I.R. MANAGEMENT			1999	973	46	20	46		108	12
13	ALLOCATED FROM S.I.R. MANAGEMENT			2000	588	102	20	29	(73)	50	13
14	ALLOCATED FROM PREFERRED BOOKKEEPING			1997	12,882	288	20	644	356	3,097	14
15	ALLOCATED FROM PREFERRED BOOKKEEPING			1999	102	20	20	5	(15)	13	15
16	ALLOCATED FROM PREFERRED BOOKKEEPING			2000	646		20	32	32	46	16
17	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1999	2,644	264	20	132	(132)	330	17
18	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1998	1,264	126	20	63	(63)	221	18
19	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1997	79	8	20	4	(4)	22	19
20	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1994	199	5	20	10	5	74	20
21	ALLOCATION FROM S.I.R PROPERTIES-SIR MANAGEMEN			1993	338	9	20	17	8	144	21
22	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1999	1,307	131	20	65	(66)	163	22
23	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1998	625	62	20	31	(31)	109	23
24	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1997	39	4	20	2	(2)	11	24
25	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1994	98	3	20	5	2	37	25
26	ALLOCATION FROM S.I.R PROPERTIES-PREF. BOOK			1993	167	5	20	8	3	71	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 62,327	$ 2,312		$ 2,449	$ 137	$ 16,139	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 495,311	$ 2,308	$ 37,674	$ 35,366	10	$ 277,022	71
72	Current Year Purchases	2,303	100	152	52	10	152	72
73	Fully Depreciated Assets	8,667				10	8,667	73
74								74
75	TOTALS	$ 506,281	$ 2,408	$ 37,826	$ 35,418		$ 285,841	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,516,852	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 163,462	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 138,338	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (25,124)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,342,546	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,186 Description: Laundry Equip $2,100, Copier $1765, Water Cooler $1,281, Ice Machine $2,040
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	2001 CHEVY V AN	$	$ 4,555	17
18	ALLOC ECM OWNERS COUNCIL			1,055	18
19	ALLOC PREF. BOOK			1,890	19
20	ALLOC SIR			3,615	20
21	TOTAL		$	$ 11,115	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 26,949	$ 32,492	1
2	Cash-Patient Deposits	7,611	7,611	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	857,109	857,109	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	7,444	7,444	6
7	Other Prepaid Expenses	775	775	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	47,891	47,891	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 947,779	$ 953,322	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		152,555	13
14	Buildings, at Historical Cost		2,274,062	14
15	Leasehold Improvements, at Historical Cost	510,778	510,778	15
16	Equipment, at Historical Cost	650,134	893,924	16
17	Accumulated Depreciation (book methods)	(634,062)	(1,624,479)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	3,021	54,837	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 529,871	$ 2,261,677	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,477,650	$ 3,214,999	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 57,614	$ 57,614	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,469	11,469	28
29	Short-Term Notes Payable	185,000	185,000	29
30	Accrued Salaries Payable	131,483	131,483	30
31	Accrued Taxes Payable (excluding real estate taxes)	7,617	7,617	31
32	Accrued Real Estate Taxes(Sch.IX-B)	133,800	133,800	32
33	Accrued Interest Payable		20,356	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	9,400	9,400	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	146	146	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 536,529	$ 556,885	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,015,695	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,015,695	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 536,529	$ 4,572,580	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 941,121	$ (1,357,581)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,477,650	$ 3,214,999	48

*(See instructions.)

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 684,399	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 684,399	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	611,972	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(355,250)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 256,722	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 941,121	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,464,946	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,464,946	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,034	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,034	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,200	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,200	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,470,180	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	780,634	31
32	Health Care	1,223,760	32
33	General Administration	1,071,554	33
	B. Capital Expense		
34	Ownership	702,873	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	79,387	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,858,208	40
41	**Income before Income Taxes (line 30 minus line 40)****	611,972	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 611,972	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,005	2,086	$ 50,314	$ 24.12	1
2	Assistant Director of Nursing	1,957	2,086	39,649	19.01	2
3	Registered Nurses	61	61	1,194	19.57	3
4	Licensed Practical Nurses	13,798	14,855	250,273	16.85	4
5	Nurse Aides & Orderlies	41,334	43,509	361,563	8.31	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,150	6,474	53,800	8.31	8
9	Activity Director	2,086	2,310	26,096	11.30	9
10	Activity Assistants	18,320	19,609	118,496	6.04	10
11	Social Service Workers	14,724	15,672	186,367	11.89	11
12	Dietician	1,915	2,078	29,161	14.03	12
13	Food Service Supervisor					13
14	Head Cook	5,260	5,803	45,549	7.85	14
15	Cook Helpers/Assistants	9,685	9,960	63,492	6.37	15
16	Dishwashers					16
17	Maintenance Workers	4,130	4,421	36,770	8.32	17
18	Housekeepers	16,382	17,340	123,550	7.13	18
19	Laundry					19
20	Administrator	1,733	2,086	72,664	34.83	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,234	12,075	111,150	9.20	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,051	2,247	19,396	8.63	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	152,825	162,672	$ 1,589,484 *	$ 9.77	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 9,600	01-03	35
36	Medical Director	Monthly	1,800	09-03	36
37	Medical Records Consultant	96	4,032	10-03	37
38	Nurse Consultant	Monthly	28,716	10-03	38
39	Pharmacist Consultant	Monthly	960	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	60	2,975	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	21	1,050	11-03	44
45	Social Service Consultant				45
46	Other(specify)				46
47	Dir of Food Servicess	Monthly	14,796	01-03	47
48	Specialized Rehab	Monthly	12,876	10a-03	48
49	TOTAL (lines 35 - 48)	177	$ 76,805		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	482	$ 22,950	10-03	50
51	Licensed Practical Nurses	182	8,251	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	664	$ 31,201		53

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DEL RYCHENER	ADMINISTRATOR		$ 72,664
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 72,664

B. Administrative - Other

Description	Amount
	$
MANAGEMENT SERVICE FEES - SEE ATTACHED	50,868
MANAGEMENT FEE - SEE ATTACHED SCHEDULE	327,058
DIRECTOR FEE - ART ROSSEAU	125
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 378,051

C. Professional Services

Vendor/Payee	Type	Amount
SCHWARTZ & FREEMAN	LEGAL	$ 7,483
MICHAEL BEST & FRIEDRICH	LEGAL	9,867
STONE, MCGUIRE & BENJAMIN	LEGAL (ADJ OUT P.5)	6,728
PREFERRED BOOKKEEPING	ACCOUNTING	19,600
JEROME I WRIGHT & ASSOC.	ACCOUNTING	1,600
FR&R	ACCOUNTING	12,703
PREFERRED BOOKKEEPING	BOOKKEEPING SERVICE	43,500
PREFERRED BOOKKEEPING	COMPUTER SERVICES	3,480
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	1,088
SIR MANAGEMENT	DIR. OF REG. SERVICES	11,748
PROPERTY VALUATION SRV.	APPRAISAL	2,500
MID AMERICA PROGRAMING	MDS SOFTWARE SUPPORT	1,320
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 121,617

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 11,263
Unemployment Compensation Insurance	13,831
FICA Taxes	118,191
Employee Health Insurance	97,557
Employee Meals	13,925
Illinois Municipal Retirement Fund (IMRF)*	
401K CONTRIBUTION	5,250
MISC EMPLOYEE BENEFITS	3,884
TOTAL (agree to Schedule V, line 22, col.8)	$ 263,901

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	6,338
Health Care Worker Background Check (Indicate # of checks performed 58)	409
PROMOTIONS	2,467
DUES	3,852
LICENSES	10,011
ALLOC PREF. BK	58
ALLOC SIR MGT.	129
ALLOC ECM OWNERS COUNCIL	43
Less: Public Relations Expense	(2,467)
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,240

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	950
SEMINAR PREF. BOOKKEEPING	83
SEMINAR SIR MANAGEMENT	212
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,245

**See instructions.

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GREENWOOD CARE LTD. # 0031971 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL $6,441**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,387**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **13,925** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees